FH
[redacted]

STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[redacted]

DECISION
[redacted]
CWA/170118

PRELIMINARY RECITALS

Pursuant to a petition filed November 15, 2015, under Wis. Admin. Code § HA 3.03, to review a decision by the Bureau of Long-Term Support in regard to Medical Assistance, a hearing was held on February 09, 2016, at Fond Du Lac, Wisconsin. The record was left open for additional submissions by Petitioner's mother.

The issue for determination is whether the agency correctly sought to discontinue Petitioner's Include, Respect, I Self Direct (IRIS) eligibility because of fraudulent billing practices.

There appeared at that time and place the following persons:

PARTIES IN INTEREST:
Petitioner:

[redacted]

Respondent:

Department of Health Services
1 West Wilson Street, Room 651
Madison, Wisconsin 53703
By: [redacted] of The Management Group for
Bureau of Long-Term Support
1 West Wilson
Madison, WI

ADMINISTRATIVE LAW JUDGE:
David D. Fleming
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner (CARES # [redacted]) is a resident of Fond Du Lac County.
2. Petitioner was sent a notice, dated November 5, 2015, that informed Petitioner that he was being disenrolled from the IRIS program as of November 21, 2015 because of fraudulent duplicate billing.

3. Petitioner has been eligible for the IRIS program. He lives with his family and his mother is the paid caregiver. She is also his guardian.
4. The IRIS agency reviewed billing records submitted by Petitioner's mother. The agency noted that she had submitted bills to the IRIS program for program payment for 24 hours of care per day for Petitioner when he was hospitalized. This triggered a closer review.
5. Petitioner's mother and guardian is the paid caregiver for Petitioner and another IRIS enrollee - [redacted]. Petitioner lives in [redacted] and [redacted] in [redacted]; about 80 miles apart.
6. Petitioner's mother submitted bills to IRIS for the period of August 2 through August 7, 2015 and noted only on hour when she was not working for Petitioner or [redacted] - 8 to 9 PM on August 2, 2015.
7. In the time period of July through September 2015 time period Petitioner's mother claimed more than 24 hours of care in 24 hours on 6 occasions; 24 out of 24 hours of care on 56 occasions and had two 10 days periods where she billed for 24 hours per day and one time period where she billed for 24 hours per day for 11 straight days.
8. Petitioner's mother submitted mileage logs for trips to music therapy for days when Petitioner did not attend music therapy.
9. Petitioner's mother had been warned in the past about these billing practices.
10. Petitioner's mother billed this Medicaid program $57,127.42 for Petitioner for the period form January 1, 2015 through November 15, 2015 and $27,740.50 for [redacted] for that same time period.

DISCUSSION

The IRIS program was developed pursuant to a Medicaid waiver obtained by the State of Wisconsin, pursuant to section 6087 of the Deficit Reduction Act of 2005 (DRA), and section 1915(j) of the Social Security Act. It is a self-directed personal care program. IRIS policies are found online at *http://www.dhs.wisconsin.gov/publications/P0/P00708.pdf.* However, as this case involves the second half of 2015, the agency cites the *IRIS Policy Manual: Work Instructions (06/2015)* (hereinafter *Manual*) in support of its disenrollment of Petitioner. The policy is not at the web site just noted, as it has been supplanted by the 2016. Nonetheless, a copy of the policy was included in the agency's hearing package. That policy provides that a participant may be disenrolled where there is substantiated fraud. *Manual, §7.1A.1.*

'Fraud' is defined as:

> Fraud refers to "any intentional deception made for personal gain or to damage another individual, group, or entity. It includes any act that constitutes fraud under applicable Federal or State law. Examples include, but are not limited to:
> …
>
> • Intentionally performing or billing services improperly, including false claims, or intentionally denying appropriate services.
>
> Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain, by means of false or fraudulent pretenses, representation, or promises, any of the money or property owned by, or under the custody of control of, any health care benefit program (18 United States Code 1347)."
> *Manual, §10.1A.1., #14.*

'Substantiated fraud' is defined as:

> …instances wherein the participant was the subject of a Fraud Allegation Review and Assessment and the allegations were substantiated. It is not required that the Department of Justice (DOJ) accepts the case for investigation prior to disenrollment of the participant. This business rule also includes participants for whom the guardians had substantiated allegations of fraud.
> *Manual, §7.1A.1, #8.*

It is also worth noting that the question of intent is generally one to be determined by the trier of fact. *State v. Lossman*, 118 Wis.2d 526 (1984). There is a general rule that a person is presumed to know and intend the probable and natural consequences of his or her own voluntary words or acts. *See*, *John F. Jelke Co. v. Beck*, 208 Wis. 650 (1932); 31A C.J.S. Evidence §131. Intention is a subjective state of mind to be determined upon all the facts. *Lecus v. American Mut. Ins. Co. of Boston*, 81 Wis.2d 183 (1977).

Petitioner's mother's provided a detailed written response (Ex. # 4) to the agency written summary as to the circumstances here (Ex # 3). It is not particularly responsive to the allegations. She blames the agency for not catching errors. She argues that there are errors in the agency calculations as to mileage and hours. She testified that she is not good at arithmetic. She contends none of her billings were intentionally fraudulent.

The case at hand is not an overpayment case so the amount of any possible overpayment involved here is not an issue. As for whether Petitioner's guardian committed fraud as defined above and the agency substantiated that fraud – this is not a close call. To claim the number of hours detailed in the findings is not a mere mistake, it is not an arithmetic error and it is not someone else's error. Petitioner's guardian is not believable. Quite simply - this was a bold scheme to defraud health a care benefit program and to obtain, by means of false or fraudulent pretenses and representation, Medicaid funds.

I note here that disenrollment from IRIS does not necessarily mean that Petitioner is ineligible for other Medicaid services. Petitioner might have to apply for Family Care or another program that does not included self-directed services but instead has more involvement from agency case managers to make certain that services are provided and paid for. The IRIS agency can assist with the transition.

CONCLUSIONS OF LAW

The IRIS agency correctly disenrolled Petitioner from the program due to fraudulent billing by Petitioner's guardian.

THEREFORE, it is **ORDERED**

That this appeal is dismissed.

REQUEST FOR A REHEARING

You may request a rehearing if you think this decision is based on a serious mistake in the facts or the law or if you have found new evidence that would change the decision. Your request must be **received within 20 days after the date of this decision.** Late requests cannot be granted.

Send your request for rehearing in writing to the Division of Hearings and Appeals, 5005 University Avenue, Suite 201, Madison, WI 53705-5400 **and** to those identified in this decision as "PARTIES IN INTEREST." Your rehearing request must explain what mistake the Administrative Law Judge made and why it is important or you must describe your new evidence and explain why you did not have it at your first hearing. If your request does not explain these things, it will be denied.

The process for requesting a rehearing may be found at Wis. Stat. § 227.49. A copy of the statutes may be found online or at your local library or courthouse.

APPEAL TO COURT

You may also appeal this decision to Circuit Court in the county where you live. Appeals must be filed with the Court **and** served either personally or by certified mail on the Secretary of the Department of Health Services, 1 West Wilson Street, Room 651, Madison, Wisconsin 53703, **and** on those identified in this decision as "PARTIES IN INTEREST" **no more than 30 days after the date of this decision** or 30 days after a denial of a timely rehearing (if you request one).

The process for Circuit Court Appeals may be found at Wis. Stat. §§ 227.52 and 227.53. A copy of the statutes may be found online or at your local library or courthouse.

Given under my hand at the City of Milwaukee,
Wisconsin, this 1st day of April, 2016

\sDavid D. Fleming
Administrative Law Judge
Division of Hearings and Appeals

State of Wisconsin\DIVISION OF HEARINGS AND APPEALS

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The preceding decision was sent to the following parties on April 1, 2016.

Bureau of Long-Term Support